Psychiatry and Spirituality at the End of Life: A Case Report

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Working with patients at the end of their lives is a special challenge for psychiatrists, but this effort can contain all types of psychiatric work in a concentrated form (1). Neuropsychiatry is used when working with these patients because of its focus on the organic mental status. Affective work is also important. In addition, psychotherapy of several schools is needed for work on existential issues, psychospiritual issues, and even transcendent issues (2).

This column describes a case study of a patient at the end of his life, detailing the patient's involvement with psychiatric and psychospiritual therapy. The column also describes how meditative techniques, including behavioral medicine tapes, assisted the patient in coming to terms with the end of life.

Diagnosis of terminal illness

Mr. X was 80 years old when he began psychiatric treatment and was still 80 years old when he died. He had been vital and active throughout his life and was, in fact, still engaged in physical activities, such as downhill skiing, when he developed a persistent cough and ascites and was given a diagnosis of lung cancer. However, shortly after he underwent chemotherapy, Mr. X developed spinal metastases and began to exhibit signs of spinal cord compression. He was hospitalized for surgical evaluation and relief of symptoms at a hospital in upstate New York. During this hospitalization, Mr. X learned that his symptoms were not correctable and that he would be crippled for the rest of his life, which was estimated to be another six to nine months.

Attempt at suicide

Mr. X decided to commit suicide by copying the method of a noted physician who had successfully committed suicide in a New York hospital. Mr. X waited until after midnight, well after the hospital staff's change of shift, and slit his wrists and throat. However, he was discovered before death, taken to surgery, repaired, and transferred to the intensive care unit.

Consultation

I was called in for immediate psychiatric consultation. During the consultation Mr. X was lucid and courteous, but he was slightly puzzled as to why he would not be allowed to complete his suicide—he felt as though his suicide attempt was rational given his condition and prognosis. His affect was not overtly depressed; however, he admitted to recent shifts in sleep and appetite, some anhedonia, and diurnal variation of mood (3). I explained that whatever one's views on rational suicide might be, New York State did not allow for the hospital to condone suicide. The consultant explained that while Mr. X was in the hospital, staff members would have to try to keep him alive. Mr. X was then told that, although he had a rationale for suicide, he seemed to exhibit some signs of clinical depression and that an antidepressant might relieve some of his suffering (3,4). Mr. X was quite agreeable, and 100 mg of sertraline was prescribed to be taken once daily in the morning.

Mr. X was invited to talk about his life experiences—including his illness, which was currently labeled as terminal—and what they meant to him (4,5). He spoke of things that brought him happiness during his life: his twin brother, his work, and his enjoyment of sports (6,7). Even though he said that he feared losing control during his illness, he quickly came to label his suicide attempt as a mistake. I reworded and reframed this label by reiterating that the term "mistake" was not an accurate or useful description of Mr. X's behavior. I also stated that no one was passing moral judgment on him but that it was the state that limited the ways in which the hospital staff was allowed to respond to the suicide attempt.

From this point in the consultation Mr. X was moved to talk about his parents, with whom he had had positive relationships but who had passed away many years before. He volunteered that he believed in an afterlife and that he would join his parents there. He acknowledged the comfort that his belief gave him; however, he voiced concerns about the intervening time and events before his death. In response to these concerns, I offered a series of guided meditation tapes that I had used successfully with other hospice patients. Mr. X accepted the offer and began meditating with the help of the tapes.

Going Home

Going Home is a series of meditation tapes designed for hospice patients. They were produced by the Monroe Institute in Faber, Virginia, and were created by Elizabeth Kubler-Ross, M.D. (8,9), Charles Tart, Ph.D., and

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Robert Monroe, the founder of the institute (10). The tapes guide the listener through meditation and trance exercises, using imagery that relates to near-death experiences, death, and the afterlife. The tapes use an open, permissive style, which allows patients to develop their own images. Also, the tapes do not promote or use specific images from any one religious group or system.

A sound technology called Hemi-Sync is used in the background of the tapes. For the *Going Home* tapes, Hemi-Sync uses soft sounds that are designed to gently entrain the brain wave frequencies—that is, to align the brain wave frequencies of the listener with those that are associated with certain states—meditative, trancelike, and dream. A number of studies have shown that both the brain wave signature, including the frequency of the predominant brain wave, and the state of consciousness can be affected by this technology (11–14). For example, when persons were exposed to Hemi-Sync sounds that were focused on a frequency of 16 cycles per second or higher, an electroencephalogram (EEG) spectrum revealed enhanced beta range activity and external arousal. Conversely, when persons were exposed to Hemi-Sync sounds that were focused on a frequency of eight cycles per second or lower, an EEG spectrum showed increased alpha and theta range activity and that the state of consciousness was similar to that of a meditative or trancelike state. These studies also indicated that this technology promotes the inter-hemisphere synchronization of brain waves, hence the name Hemi-Sync. Furthermore, preliminary work suggests that brain wave shifts may be more pronounced with appropriate tapes than with hypnosis or meditation alone (14).

Placement issues and the nursing home

During the next month Mr. X healed from his wounds and his depression improved. During this time he listened to the *Going Home* tapes. Members of the hospital administration believed that they were in a precarious situation, because they would be liable if Mr. X tried to commit suicide again. Although Mr. X had promised not to attempt suicide, the circumstances that led up to the suicide attempt still remained. The members of the hospital administration were reluctant to accept Mr. X's assurances, as were a number of local nursing homes, including the nursing home that was officially associated with the hospital. The consultant advised Mr. X's treatment team to involve the local hospice that was affiliated with the hospital. Unfortunately, this hospice had just entered a period of organizational turmoil. At a team meeting among hospice and hospital staff members that was called to address treatment and placement options for Mr. X, a hospice administrator stated, "This man must be taught a lesson. There are consequences for his actions." The hospice did not accept Mr. X. However, a nursing home near the hospital did accept Mr. X after he agreed to a "no suicide" contract. A nurse clinician from the hospital and I agreed to visit Mr. X in this new setting.

While Mr. X was in the nursing home, he continued to meditate with the help of the *Going Home* tapes and did some additional trance exercises with my help. Some of the exercises that I used were adapted from the conscious dreaming exercises of Moss (15) and the creative dreaming techniques of Garfield (16). Other exercises were adapted from Cerney's (17,18) work, which allows the person to work through grief by visualizing loved ones who have passed away. I also adapted techniques from Moen (19), who had, in turn, adapted techniques from the Monroe Institute. These exercises focused on dreamlike scenarios in which Mr. X encountered and talked with his late parents and other persons of emotional importance who had died. Some of the exercises that were used allowed Mr. X to explore spontaneous imageries of positive possible afterlife environments. It should be noted that these exercises do not depend on the existence or proof of an afterlife—although recent research on this subject is thought provoking (20)—but merely a person's interest in meditating on the subject. Mr. X reported satisfying meditative and trance experiences concerning dying, meeting his parents, and the afterlife. He reported a cessation of depression symptoms and satisfaction with his life at the nursing home. The nursing home, in turn, reported that Mr. X was active in physical therapy and program activities and that he was one of the most beloved members in the nursing home community. His twin brother visited multiple times from a nearby state, despite a severe illness of his own. Mr. X reported that the brothers achieved a sense of emotional closure. About four months after Mr. X was hospitalized, he experienced one day of increased weakness and died peacefully in his sleep.

Conclusions

This case study demonstrated that rational suicide can have aspects of syndromic depression, which can respond to traditional pharmacotherapy. The study also demonstrated that existential or experiential psychotherapy can have a particularly satisfying role in end-of-life therapy. In addition, the case study showed that even organizations that are dedicated to end-of-life treatment, such as hospices, can fall short and benefit from psychiatric guidance. Furthermore, if a person's beliefs render projective, meditation, and trance techniques acceptable, they can be useful components in end-of-life therapy. Technological adjuncts, such as the Hemi-Sync tapes in the *Going Home* series, can be helpful and can enhance the effectiveness of other techniques, which can empower patients in the last phase of their lives. ♦

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